FOR OHF USE

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033712

Facility Name: OAKWOOD ESTATE

Address: 2213 VETERANS ROAD (Number) MORTON (City) 61550 (Zip Code)

County: TAZEWELL

Telephone Number: 309-266-9781 **Fax #** 309-266-9468

IDPA ID Number: 23-7033585-003

Date of Initial License for Current Owners: 08/08/88

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(c) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: MATT STEFFEN **Telephone Number:** 309-266-9781

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) HELEN SCHUON
(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) JEROME D. MCDADE, SHAREHOLDER
(Firm Name & Address) HEINOLD-BANWART, LTD.
2400 N. MAIN, EAST PEORIA, IL 61611
(Telephone) 309-694-4251 Fax # 309-694-4202

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 12/1/94

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	4,963			4,963	13
14	TOTALS	4,963			4,963	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 84.98%

D. How many bed-hold days during this year were paid by Public Aid?
160 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/15/88

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/00 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	28,011	1,654	1,323	30,988	(15)	30,973		30,973			1
2	Food Purchase		25,131		25,131		25,131		25,131			2
3	Housekeeping		1,525		1,525		1,525		1,525			3
4	Laundry		1,223		1,223		1,223		1,223			4
5	Heat and Other Utilities			11,837	11,837		11,837		11,837			5
6	Maintenance	4,160	1,498	3,583	9,241	(35)	9,206	(2,924)	6,282			6
7	Other (specify):*											7
8	**TOTAL General Services**	32,171	31,031	16,743	79,945	(50)	79,895	(2,924)	76,971			8
	B. Health Care and Programs											
9	Medical Director			234	234		234		234			9
10	Nursing and Medical Records	20,578	4,323	2,977	27,878	(3,081)	24,797		24,797			10
10a	Therapy	216,671		9,159	225,830	(193)	225,637		225,637			10a
11	Activities		1,265		1,265	990	2,255		2,255			11
12	Social Services		60	570	630	(27)	603		603			12
13	Nurse Aide Training	2,051			2,051	954	3,005		3,005			13
14	Program Transportation			859	859	(859)						14
15	Other (specify):* (Day Programming)		17		17	(23)	(6)		(6)			15
16	**TOTAL Health Care and Programs**	239,300	5,665	13,799	258,764	(2,239)	256,525		256,525			16
	C. General Administration											
17	Administrative	17,423			17,423	(143)	17,280		17,280			17
18	Directors Fees											18
19	Professional Services			2,067	2,067		2,067		2,067			19
20	Dues, Fees, Subscriptions & Promotions			2,904	2,904		2,904	(127)	2,777			20
21	Clerical & General Office Expenses	19,228	4,798	3,607	27,633	181	27,814		27,814			21
22	Employee Benefits & Payroll Taxes			85,041	85,041		85,041		85,041			22
23	Inservice Training & Education			520	520		520		520			23
24	Travel and Seminar			732	732		732	(365)	367			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			4,449	4,449		4,449		4,449			26
27	Other (specify):*			1,178	1,178	(998)	180		180			27
28	**TOTAL General Administration**	36,651	4,798	100,498	141,947	(960)	140,987	(492)	140,495			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	308,122	41,494	131,040	480,656	(3,249)	477,407	(3,416)	473,991			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number OAKWOOD ESTATE #0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			18,062	18,062		18,062	2,470	20,532			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			1,835	1,835		1,835		1,835			34
35	Rent-Equipment & Vehicles			181	181	(181)						35
36	Other (specify):*											36
37	**TOTAL Ownership**			20,078	20,078	(181)	19,897	2,470	22,367			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation					859	859	(859)				38
39	Ancillary Service Centers					2,571	2,571		2,571			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			31,500	31,500		31,500		31,500			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			31,500	31,500	3,430	34,930	(859)	34,071			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	308,122	41,494	182,618	532,234		532,234	(1,805)	530,429			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(127)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,678)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,805)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,805)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	X		$ 859	14	38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ 859		47

STATE OF ILLINOIS

OAKWOOD ESTATE

ID# 0033712

Report Period Beginning: 7/1/99

Ending: 6/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Out of State Travel	$ (365)	24	1
2	Offset travel income	(859)	38	2
3	Offset travel income	(2,924)	6	3
4	Adjust depreciation to straight-line	2,470	30	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
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73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(1,678)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(2,924)	0	0	0	0	0	0	0	0	0	0	(2,924)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,924)	0	0	0	0	0	0	0	0	0	0	(2,924)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(127)	0	0	0	0	0	0	0	0	0	0	(127)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(365)	0	0	0	0	0	0	0	0	0	0	(365)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(492)	0	0	0	0	0	0	0	0	0	0	(492)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,416)	0	0	0	0	0	0	0	0	0	0	(3,416)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number OAKWOOD ESTATE # 0033712 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	2,470	0	0	0	0	0	0	0	0	0	0	2,470	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	2,470	0	0	0	0	0	0	0	0	0	0	2,470	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	(859)	0	0	0	0	0	0	0	0	0	0	(859)	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(859)	0	0	0	0	0	0	0	0	0	0	(859)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(1,805)	0	0	0	0	0	0	0	0	0	0	(1,805)	45

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Apostolic Christian Home for the Handicappe	100.00%	Apostolic Christian Timber Ridge	Morton	Community	Morton	Residential Service
Apostolic Christian Home for the Handicappe	100.00%	Linden Estate	Morton	Residential Services		for the Disabled

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Office rent	$ 1,835	Apostolic Christian Timber Ridge	100.00%	$ 1,835	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,835			$ 1,835	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	Michael Dubach	President	Director	0.00	738	0.5		Travel	$ 113	line24; col. 3	1
2	Jerry Kieser	Sec/ Treas	Director	0.00		1					2
3	Jerry Christensen	Director	Director	0.00		0.5					3
4	Irvin Furrer	Director	Director	0.00		0.5					4
5	Ron Gasser	Director	Director	0.00	1,434	0.5		Travel	252	line24; col. 3	5
6	John Knobloch	Director	Director	0.00		0.5					6
7	Edward Sauder	Director	Director	0.00		0.5					7
8	Dan Schumacher	Director	Director	0.00		0.5					8
9	Richard Steffen	Director	Director	0.00		0.5					9
10											10
11											11
12											12
13								TOTAL	$ 365		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Apostolic Christian Timber Ridge
Street Address: 2125 Veterans Rd.
City / State / Zip Code: Morton, IL 61550
Phone Number: (309-266-9781
Fax Number: (309-266-9468

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	34	Office rent	No. of residents	143	143	$ 16,403	$	16	$ 1,835	1
2										2
3	6,10a,17,21	Wages	Direct cost/ # of hours	1,756	1756	25,185	25,185	1,756	25,185	3
4										4
5	22	Fringes	Direct cost	100	100	6,951		100	6,951	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 48,539	$ 25,185		$ 33,971	25

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,140 B. General Construction Type: Exterior Brick Veneer Frame Wood frame Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apostolic Christian Timber Ridge is located adjacent to this nursing home's grounds.

Type of business: Nursing home (IDPA #0016220)
Square footage: land - 1,345,699 sq. ft; building - 50,135 sq. ft.
Beds: 98

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	16 bed home	91,781	1988	$ 9,477	1
2					2
3	TOTALS	91,781		$ 9,477	3

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16			1988	$ 202,314	$ 4,934	40	$ 5,058	$ 124	$ 60,048	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Porch			1995	6,829	166	40	170	4	918	9
10	Door			1997	775	19	40	19		76	10
11	Generator wiring			1999	1,623	40	40	40		60	11
12	Carpet			2000	4,866	221	10	243	22	243	12
13	Generator circuits			2000	108	4	15	4	(0)	4	13
14	Garage			1988	23,005	885	25	920	35	10,924	14
15	Driveway			1988	16,544	1,034	15	1,103	69	12,710	15
16	Irrigation system			1988	7,650	294	25	306	12	3,825	16
17	Drainage/sewer			1988	5,655	182	30	189	7	2,214	17
18	Concrete			1988	7,277	347	20	364	17	4,549	18
19	Parking signs			1988	41	3	15	3		43	19
20	Underground gas & water lines			1988	621	20	30	21	1	259	20
21	Landscaping			1988	13,616		10	166	166	13,782	21
22	Resurface driveway			1999	10,526	658	15	702	44	1,053	22
23	Sprinkler system			1988	24,890	957	25	996	39	11,407	23
24	Lighting			1988	3,764	171	10	188	17	3,952	24
25	Cabinetry			1988	24,992	1,190	20	1,249	59	15,620	25
26	Plumbing			1988	36,140	1,184	25	1,446	262	16,625	26
27	Heating & ac			1988	13,273	829	15	885	56	11,061	27
28	Wiring & phone equip			1988	24,211	1,153	20	1,210	57	13,921	28
29	Cabinets			1991	2,010	96	20	101	5	955	29
30	Generator			2000	3,854	121	15	128	7	128	30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 434,584	$ 14,508		$ 15,511	$ 1,003	$ 184,377	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 14,191	$ 425	$ 1,811	$ 1,386	five-twenty	$ 8,864	37
38	Current Year Purchases	8,842	504	585	81	five-twenty	585	38
39	Fully Depreciated Assets	46,726	257	257		five-twenty	46,726	39
40								40
41	TOTALS	$ 69,759	$ 1,186	$ 2,653	$ 1,467		$ 56,175	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Residents & in-service	1988 Chevy Celebrity	1993	$ 6,923	$	$	$	5	$ 6,923	42
43	Residents & in-service	2000 Venture Van	2000	23,675	2,368	2,368		5	2,368	43
44										44
45										45
46	TOTALS			$ 30,598	$ 2,368	$ 2,368	$		$ 9,291	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 544,418	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 18,062	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 20,532	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 2,470	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 249,843	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)	338	510		848
4	Clinical Wages	(b)	615	588		1,203
5	In-House Trainer Wages	(c)	572	382		954
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$ 1,525	$ 1,480	$	$ 3,005
10	SUM OF line 9, col. 1 and 2	(e)	$ 3,005			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number OAKWOOD ESTATE **#** 0033712 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 500	$ 264,381	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	61,987	774,433	3
4	Supply Inventory (priced at 3,519)	3,519	48,435	4
5	Short-Term Investments		3,825,546	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	883	8,934	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Employee Receivables	195	71,752	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 67,084	$ 4,993,481	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	71,408	613,218	13
14	Buildings, at Historical Cost	372,653	3,458,882	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	100,357	1,301,412	16
17	Accumulated Depreciation (book methods)	(247,373)	(2,625,489)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	26,269	46,100	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(26,269)	(46,100)	20
21	Restricted Funds		2,667,979	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Cash value - life insurance		14,335	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 297,045	$ 5,430,337	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 364,129	$ 10,423,818	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 3,950	$ 135,882	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(3,130)	73,043	30
31	Accrued Taxes Payable (excluding real estate taxes)		6,767	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	20,881	179,490	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 21,701	$ 395,182	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 21,701	$ 395,182	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 342,428	$ 10,028,636	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 364,129	$ 10,423,818	48

***(See instructions.)**

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 314,733	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 314,733	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	27,695	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 27,695	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 342,428	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 509,256	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 509,256	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants	3,783	10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,783	23
	D. Non-Operating Revenue		
24	Contributions	46,505	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 46,505	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on sale of fixed assets	385	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 385	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 559,929	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	79,945	31
32	Health Care	258,764	32
33	General Administration	141,947	33
	B. Capital Expense		
34	Ownership	20,078	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	31,500	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 532,234	40
41	**Income before Income Taxes (line 30 minus line 40)****	27,695	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 27,695	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	869	899	20,578	22.89	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	501	501	2,051	4.09	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,420	1,618	19,776	12.22	14
15	Cook Helpers/Assistants	839	997	8,235	8.26	15
16	Dishwashers					16
17	Maintenance Workers	261	261	4,160	15.94	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	544	744	17,423	23.42	20
21	Assistant Administrator					21
22	Other Administrative	240	240	5,500	22.92	22
23	Office Manager					23
24	Clerical	1,207	1,207	13,728	11.37	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,908	2,090	36,581	17.50	29
30	Habilitation Aides (DD Homes)	18,089	19,383	179,755	9.27	30
31	Medical Records					31
32	Other Health C: OT/PT/Speech	30	30	335	11.17	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	25,908	27,970	$ 308,122 *	$ 11.02	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	24	$ 1,323	1-3	35
36	Medical Director	flat fee	234	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	flat fee	406	10-3	39
40	Physical Therapy Consultant	14	603	10a-3	40
41	Occupational Therapy Consultant	3	186	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	20	1,490	10a-3	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Psychologist	7	541	12-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	68	$ 4,783		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	441	6,880	10a-3	52
53	TOTAL (lines 50 - 52)	441	$ 6,880		53

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Helen Schuon	Administrator	0	$ 15,716
Ron Messner	Administrator	0	1,707
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 17,423

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heinold-Banwart, Ltd.	Acctg. & Computer Support	$ 2,067
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 2,067

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 4,074
Unemployment Compensation Insurance	
FICA Taxes	24,399
Employee Health Insurance	19,619
Employee Meals	14,545
Illinois Municipal Retirement Fund (IMRF)*	
Retirement plan	21,215
Employee physicals	109
Employee promotion	1,080
TOTAL (agree to Schedule V, line 22, col.8)	$ 85,041

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,055
Health Care Worker Background Check	96
(Indicate # of checks performed 8)	
Promotion	127
Vehicle & other licenses	128
IHCA dues	793
Dues & subscriptions	705
Less: Public Relations Expense	(127)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,777

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Board of Directors travel reimb	365
In-State Travel	
Administrative travel	367
Seminar Expense	
Less out-of-state travel	(365)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 367

**See instructions.

Facility Name & ID Number OAKWOOD ESTATE # 0033712 Report Period Beginning: 7/1/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number OAKWOOD ESTATE **#** 0033712 **Report Period Beginning:** 7/1/99 **Ending:** 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assn - $793**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **31,500**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **14,545** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No - adjusted out**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **3,783**
c. What percent of all travel expense relates to transportation of nurses and patients? **54%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Oakwood Estate
FYE 6/30/2000 **#0033712**
Subschedules

Schedule V - Reclassifications

Lines	Description	Amount Increase	Amount Decrease
21	Communication equip rental	181	
35	Communication equip rental		181
11	Donated labor	998	
27	Donated labor		998
38	Medically necessary transporation	859	
14	Medically necessary transporation		859
13	Nurse aide trainer wages	954	
1	Nurse aide trainer wages		15
6	Nurse aide trainer wages		35
17	Nurse aide trainer wages		143
10	Nurse aide trainer wages		510
10a	Nurse aide trainer wages		193
11	Nurse aide trainer wages		8
12	Nurse aide trainer wages		27
15	Nurse aide trainer wages		23
39	Dental costs	2571	
10	Dental costs		2571
		5563	5563

Schedule VI B, Line 31 - Non-paid workers

	Time in Hours	Time in Dollars
Activities - Donated Labor	181.50	998

Schedule VII - Compensation Received From Other Nursing Homes

Michael Dubach - $738 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate

Ron Gasser- $1,434 - reimbursement of travel expenses received from Apostolic Christian Timber Ridge & Linden Estate

Sch. XVII - Income Statement, Line 41 - Income Before Taxes

Income before taxes per cost report	27,695
Income from related parties	217,949
Estimated excess for year, Form 990, p.1, line 18	245,644

Schedule XIX, D - Employee Benefits and Payroll Taxes - FICA calculation

Salaries, Sch V, Line 45, Col 1	308,122
Add accrued wages a/o 6/30/99	3,272
Less accrued wages a/o 6/30/00	3,130
Add wages included in employee meal calculation	7,774
Cash basis salaries	322,298
FICA rate	0.0765
Calculated FICA	24,656
FICA per Sch XIX	24,399
Unknown variance	257

Sch. XX - General Information

12. Nurse Aide Trainer Wages:

Administrator	143
PT/OT	193
Activities Director	8
Head Cook	15
Maintenance	35
Nursing	510
Social Services	27
Day Programming	23
	954